# BUSH HOSPITAL

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Bonda Hospital, P.O. Bonda, via Umtali, Rhodesia

THERE IS SOME similarity about the origins of most mission hospitals. They start from small beginnings, perhaps with one hut, then sprawl to provide space for their patients, constantly hampered by lack of funds. Bonda Hospital had its nucleus in Mrs. Broderick's kitchen in 1911. Mrs. Broderick was the wife of the first Anglican priest to arrive in the Inyanga district of the eastern highlands of Rhodesia, nearly 6,000 feet above sea level (Fig. 1). She treated African babies and children and helped at village confinements.

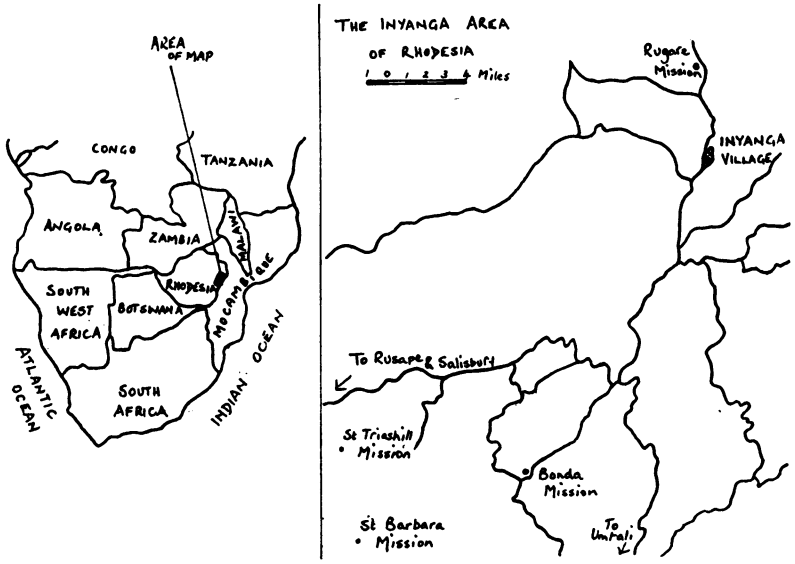


Fig. 1.

This part of the country is wild and mountainous, with huge granite outcrops. Like most of southern Africa it is subject to numerous droughts, and on several occasions veld and bush fires have threatened to destroy the hospital and mission. At first the roads were extremely bad. The first road to Bonda was likened to 'a dragon guarding the gates', and when a new 'improved' road was made it resembled 'a snake reared up to strike'. The nearest railway station is 45 miles away at Rusape. The post is brought only twice a week, as it was more than 30 years ago.

(Ann. Roy. Coll. Surg. Engl. 1971, vol. 49)

After Canon Broderick came Archdeacon Christelow, who organized the building of the first part of the hospital, consisting of two wards 12 by 12 feet, a dispensary 6 by 6 feet, a cubicle for a nurse, and a 12-foot verandah. This was in 1928. The hospital soon had to be closed on account of lack of funds, which is still the most formidable obstacle to its efficient administration; another reason was that the nearest doctor lived far away. As in most rural African hospitals, Bonda was regarded with suspicion by the Africans, who believed (as most still do) in witchcraft.

It was not until 1937, when the Rev. Dr. Denys Taylor, an Anglican missionary, came here that the hospital was resuscitated. Soon afterwards Sister Lorna Page joined him, and these two gained the confidence of the Africans, who began to arrive in increasing numbers. The medical superintendent of a hospital like this requires engineering as well as medical skill. Dr. Taylor, who fortunately has a bent towards engineering, usefully combined his engineering knowledge with his training as a priest and a doctor. He personally supervised the building operations when a theatre was added, water laid on, an engine installed to provide electric light for three hours every night, and a primitive system of cement furrows established to carry off waste water.

Money was scarce, but friends in England subscribed funds. The two wards were soon grossly overcrowded. Five huts, 12 by 12 feet, were built to house the less ill patients, and a separate maternity block was completed in 1944, with no ceilings, home-made doors, and windows of a sort. However, 300 confinements were conducted there in the first year. This block is still in the same place but has had a 'face-lift' since it was built.

Further construction started on a new main block in 1945. The Beit Trust, at Sir Alfred Beit's invitation, paid for half of this, while the Government paid for the other half, and a donation from Canon Broderick helped towards the building of a children's ward block. The surgical wards were completed in 1951 (Fig. 2).

The value, excellence and usefulness of a mission hospital can, in my experience of several, be gauged largely by the length of time during which the medical and nursing staffs remain in it. The staff soon leave a hospital which is run inefficiently, or in which an atmosphere of friendliness and interest in its welfare does not prevail. Bonda has a record of devoted service by many members of the staff. Dr. Taylor has been here since 1937, and part-time doctors and some of the European sisters have stayed for long periods. Sister Doris Worssam, who joined the staff in 1948, is still here. Sister Lorna Page remained for 10 years, and the present matron, Mrs. Peggy Tendall, for eight years. Though the African sisters are paid the same salaries as European, these being subsidised by the Government, they unfortunately do not stay so long.

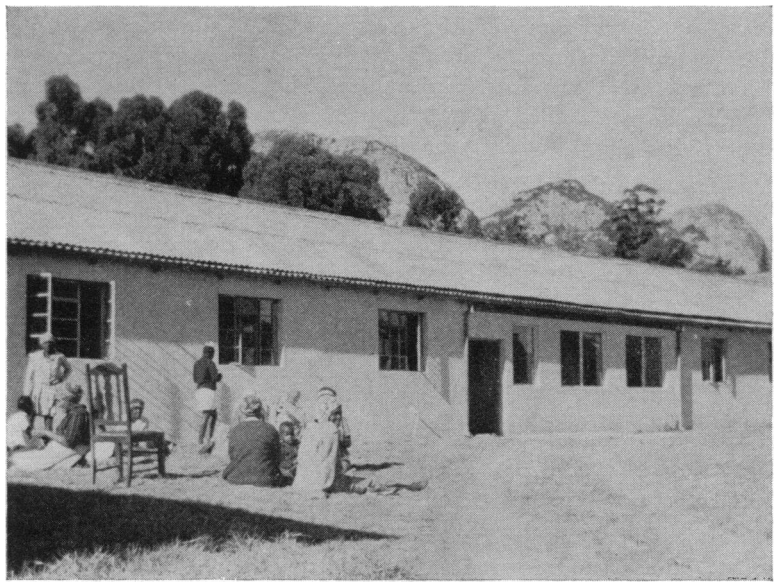

Fig. 2. Patients and a nurse in the foreground of the main hospital building, behind which tower granite outcrops.

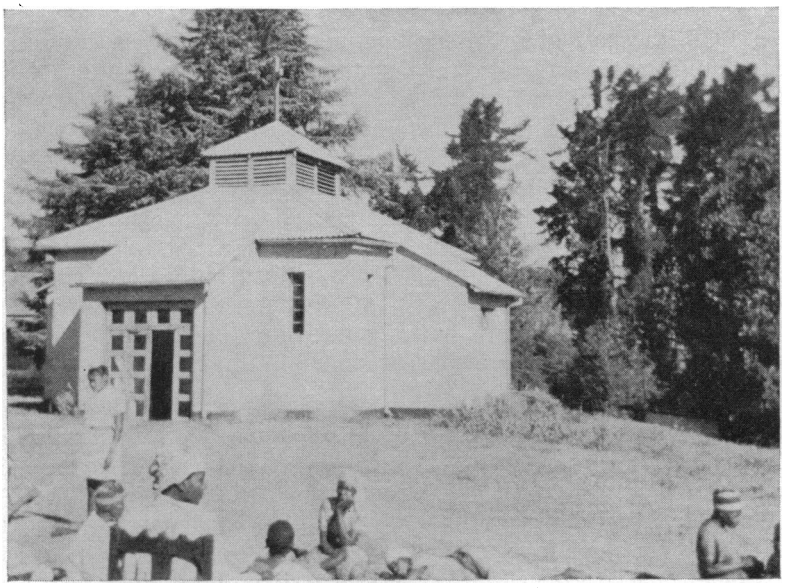

Fig. 3. This chapel was built in the middle of the hospital in 1951.

One reason for this probably is that African women nearly all get married early and have many children. Three of the longest and most valued stayers among the African nursing staff are the medical assistants who were trained at Bonda. All three are excellent nurses, but as they are not state registered they are not entitled to anything like the salaries as the sisters trained in Salisbury or Bulawayo who are state-registered.

Dr. Taylor realized early the importance of training African nurses to look after their own people. In 1938 the first six trainees were given instruction in nursing, elementary medicine and hygiene, their course lasting three years. In 1943 the first batch of 'standard 6' girls enrolled, and in 1953 the course of instruction was lengthened to four years, with the object of helping the African to take responsibility. On one occasion soon afterwards, the nurses prepared for and helped with a major operation in the general theatre, and while it was in progress another group of nurses prepared for a Caesarean section in the maternity theatre. This was late in the evening. By general consent of the European staff, there were no sisters on duty to give any help or direction, but at both operations all went well and nothing was forgotten. To-day, all preparations for and assistance at operations by day and night are carried out entirely by the African nursing staff. The African girls are trained as medical assistants, spending three years in the medical and surgical wards and an extra year learning midwifery. When qualified, most are snapped up by the Government hospitals, where the matrons are well aware of the excellent teaching which they receive at Bonda.

In 1938, the cost of providing treatment shows a strong contrast to that of to-day. Consultation and a bottle of medicine cost the patient 6d. for the first visit and 3d. for each subsequent visit. In-patients paid 1s. per week, 5s. for a minor operation, and 10s. for a major operation or maternity care and delivery. To-day patients pay the equivalent of 3s. for the first out-patient visit, while in-patients pay 2s. 4d. per day for a hospital bed and 1s. 9d. per day for food if this is provided. Most, however, prefer to supply their own food and have a relative to cook for them. A major operation costs £3.50. The patients also pay for expensive drugs such as Hycanthone (Etranol) for bilharzia, which did not exist in the 1930s. Many patients, however, who are thought to be indigent are treated free. There are at present about 150 beds.

The increased charges for hospital services between 1938 and 1971 reflect the increase in the cost of drugs, dressings, and other materials. Salaries, too, have considerably increased, but these are partly met by the Government. The medical assistant trainees perform the bulk of the nursing. The hospital derives its funds from the Rhodesian Government, the Society for the Propagation of the Gospel, donations from private individuals and organizations such as the Beit Trust, and fees from patients, but the money available is insufficient to introduce modern

improvements. Bonda is still desperately poor, and there is hardly any waste. The extremes to which economy is practised is exemplified by the fact that the patients' temperatures are recorded on the charts in pencil, and this is rubbed out afterwards and the same charts used for other patients. When writing up a report for publication on a patient who had been discharged I found that I could not have recorded the patient's temperature without H. G. Wells's time machine and a capacity for clairvoyance.

The organization of surgery here depends for its success on technical simplicity. Dr. Taylor does all his operations with a medical assistant (nurse) as anaesthetist and with one nurse (usually a trainee) assisting him. She looks after the instruments and assists at the same time. His technique is such that he can perform a hysterectomy in less than 45 minutes under these conditions on a woman with a haemoglobin value of less than 40%. The patient upon whom I watched him perform this operation was discharged fit in less than three weeks, with nothing to boost her Hb value but a few injections of Imferon. African patients, who are not usually 'operation prone', come here asking for a hysterectomy!

The only general anaesthetics which I have seen used here are chloroform and ether, because these are the only ones which the hospital can afford. Fourth-year medical trainees at Bonda give reasonably good anaesthetics (Fig. 4). My contact with Bonda has reconverted me to the belief instilled in me by Dr. Hedley when I was a student at St. Thomas's that chloroform and ether on an open mask are good anaesthetics. Their main disadvantages are that the stomach must be empty, foreign bodies from the air and food passages cannot be removed with serenity, the thorax cannot safely be opened, and operations on the head and neck and upper abdomen are rendered more difficult. The use of a Boyle's machine would be fraught with difficulties, for it would be hard to obtain a constant supply of cylinders of gas and oxygen for Bonda from Salisbury, even if we could afford to pay for them. An E.M.O. machine would prove a great asset, and I hope that we shall obtain one soon, for this would be much cheaper to maintain in constant use than a Boyle's machine and would meet many of our requirements.

The lack of good surgical instruments is another obstacle, which Dr. Taylor has largely overcome by dexterity in operating. Hearing that he was to perform a myomectomy, I went to watch him, interested in how he would secure haemostasis without a myomectomy clamp. He simply held the uterus tightly in his left hand and incised over the myoma, bisected it, and shelled it out with his right. Bleeding occurred when he had to let go with his left hand in order to sew up the uterus, as he remarked that the nurses could not hold the uterus effectively enough to arrest haemorrhage. He has become so accustomed to working with a nurse to assist that I think he would be hindered rather than helped by a doctor. When I mentioned the value of a myomectomy clamp he replied that he had never seen one! He learned the elements of surgery as a student, and has taught himself to do almost all the operations required here

which can be done without endotracheal anaesthesia and relaxants with the minimum of instruments, most of which are old and unreliable, for he brought out a good many of them when he came in 1937.

I admired the unhurried technique with which he performed a suprapubic prostatectomy by his own method, based on the original Freyer's technique, in half the time which it takes me. When I watched him perform a skin graft for burns in a child with an old and very blunt razor I should have liked to take a movie of 'How to do a skin graft without instruments'. I cannot forbear to mention that his only medical qualification is the L.M.S.S.A., and patients come to him from far away for operations.

I have mentioned Dr. Taylor's operations to illustrate what can be done in a primitive hospital with indifferent tools. Anyone less patient than he would become tired of my constant complaints about lack of instruments and drugs which he has come to accept over the years almost without a second thought. Several advances have recenty been introduced. The single neon strip high up in the theatre ceiling, which was its only light, has been replaced by two

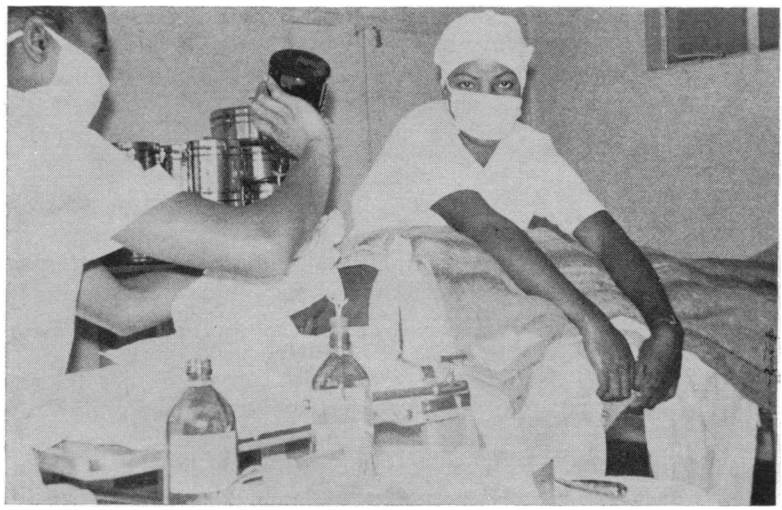

Fig. 4. Nurse Annie Dube is inducing with chlorofrom while a nurse restrains the patient.

longer and brighter neon strips lower down. A head lamp and a hand lamp have been provided. A good ophthalmoscope, an auroscope and some cannulas for intravenous infusion are welcome additions and others are on the way—at least I hope so.

Blood transfusions have also proved a difficult problem. They have been given sporadically over many years, but for much of the time Dr. Taylor has been here by himself with too much other work to do to organize a blood bank. We hope to start a proper blood transfusion service soon under the direction of our part-time tuberculosis officer, Dr. Sutherland, who has never accepted the salary due to her. She has just completed a course on blood transfusion in Salisbury.

Bonda is full of plans and aspirations. The vital question is not 'What do we want to do next? but 'How much can we afford to spend?'